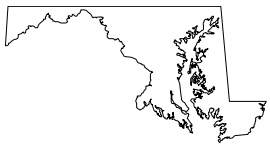


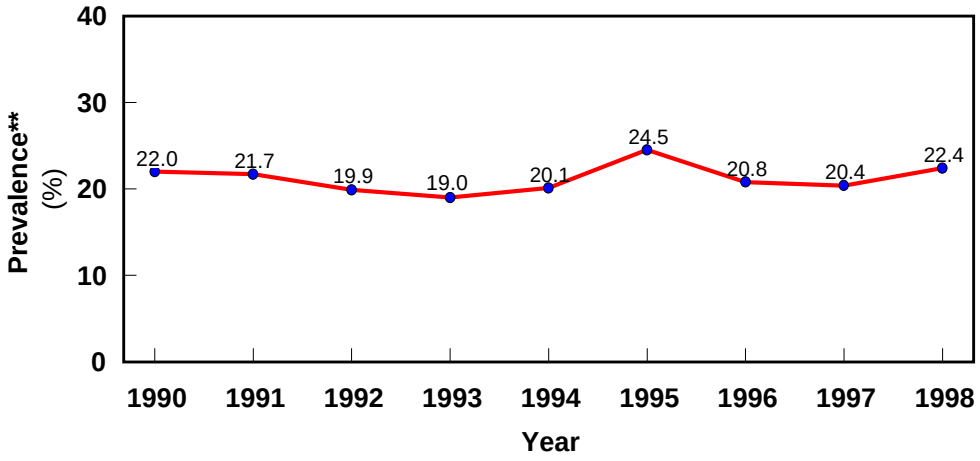
REDUCING THE USE OF TOBACCO PRODUCTS

Problem

The use of tobacco products is the single largest cause of preventable death each year in the United States and Maryland. More Marylanders die prematurely from their use or exposure to tobacco products than from the *combined* effects of AIDS, alcohol, car accidents, murders, suicides, illegal drug use, and fires. Tobacco-related disease is estimated to result in the premature death of 7,500 Marylanders each year. One in three youth who presently use tobacco products will ultimately die prematurely from a tobacco-related disease. Although most commonly associated with cancer, tobacco is a risk factor in many other diseases and conditions as well. Tobacco is a risk factor in the top four leading diseases causing death in Maryland: cancer; heart disease and stroke; pulmonary disease; and diabetes. The Centers for Disease Control and Prevention (CDC) has identified at least 27 separate conditions for which tobacco is a risk factor.

Tobacco use in the State by adults has declined significantly from the usage rates of the 1950s and 1960s. However, in the 1990s, this rate of decline slowed considerably and even reversed itself at times. Although Maryland does not conduct any survey of tobacco use at the county level, statewide data from 1996-1998 was recently aggregated to estimate the extent to which tobacco use varies by jurisdiction. Tobacco use by Maryland youth during the 1990s also showed contrary trends and considerable variation among jurisdictions.

Current Smokers* Among Adults Age 18 and Over, 1990-1998



*Current smokers is defined as respondents who have smoked at least 100 cigarettes in their lifetime and now smoke everyday o or some days.
**Prevalence estimates were weighted to the Maryland census population; Respondents who answered "Don't know" or "Refused" were excluded from the denominator.

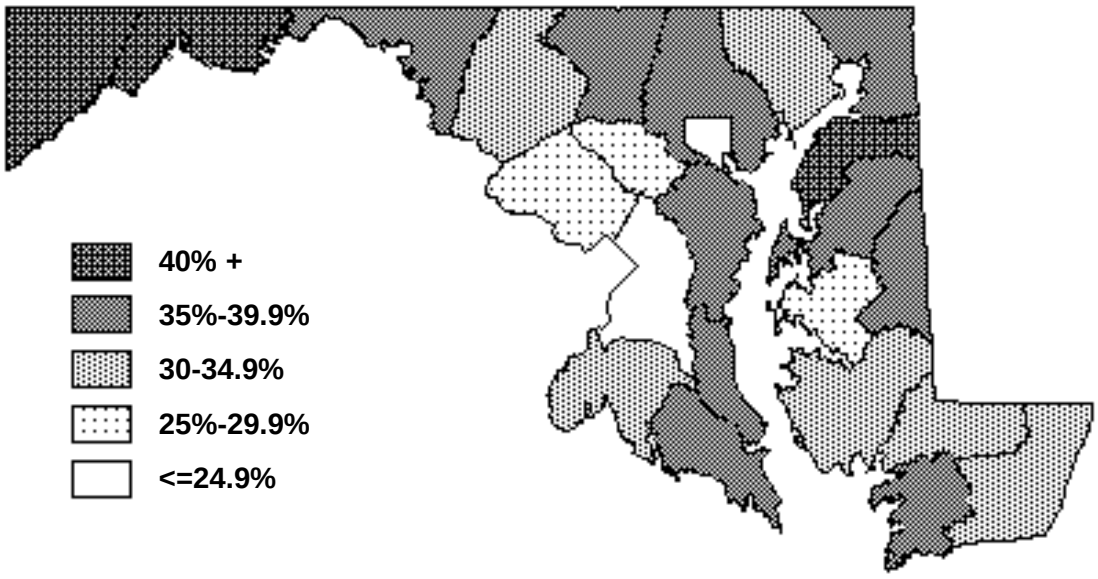
Source: Maryland Behavioral Risk Factor Surveillance System

Secondhand smoke presents a very real health hazard to those in the population that suffer from asthma and other breathing disorders. Notwithstanding the federal court ruling which voided the Environmental Protection Agency's report on secondhand smoke, ample independent scientific evidence exists to establish that it represents a cancer risk. Tobacco use and exposure to second hand tobacco smoke is a problem that affects every segment of the population. Unborn infants are exposed to its effects when their mothers smoke during pregnancy. Children are affected when adults in their household smoke around them. Adult non-smokers are affected by those who smoke around them. Racial and ethnic minority groups suffer disproportionately from tobacco-related disease and remain targets of the multi-billion dollar marketing and media campaigns of the tobacco industry.

Determinants

No single factor determines patterns of tobacco use. Research has shown tobacco use to result from a complex interaction of multiple factors, including: socio-economic status, cultural characteristics, stress, biological events, targeted marketing, pricing, and varying capacities of local communities to launch and sustain comprehensive tobacco use prevention and cessation activities and programs. The extent of tobacco use varies significantly among communities in Maryland, between age and socio-economic groups. Notwithstanding substantial decreases in the overall use of tobacco products since 1960, in the 1990s this downward trend leveled off and even reversed itself for some sub-population groups.

Prevalence of Youth Cigarette Use
Maryland High School Seniors, 1996-1998



Source: Maryland Adolescent Survey, 1998 (Kent and Prince George's Counties are 1996 data)

Nicotine Addiction. Even in light of the complex interaction of factors which may lead to the initiation of tobacco use, or reinforce the propriety of continued use for the tobacco user, the primary factor underlying the long-term sustained use of tobacco products is nicotine addiction. Nicotine's ability to addict the tobacco user is greater than that of alcohol or even cocaine. With regular use, the risk of addiction to alcohol is one in nine, to cocaine one in four, and nicotine one in three. A smoker can become addicted to nicotine after smoking as few as 100 cigarettes (five packs). An estimated 50% of adult tobacco users in Maryland make serious attempts to stop using tobacco each year, with very little success.

Youth Access to Tobacco Products. Tobacco products may not be sold to or possessed by youth who are under the age of 18 in Maryland. Nonetheless, an estimated 10.4 million packs of cigarettes are sold to this population annually. Of those Maryland youth who reported buying their cigarettes in a store, more than half are not asked to show proof that they are of legal age to purchase them. In compliance inspections conducted in 1999, underage youth were successful in purchasing tobacco products 64.7% of the time from vending machines and 31% of the time from store clerks. Adults who use tobacco products overwhelmingly report that their tobacco use began before the age of 18. Maryland's high school seniors report similar experience. Of the youth who use tobacco products, 70% wish that they had never started and have been unable to quit on their own. If experimentation and initiation of tobacco use can be delayed to adulthood, preferably after age 24, then there is substantially less likelihood of becoming a lifetime tobacco user.

Tobacco Industry Marketing and Advertising. The tobacco industry invests in excess of $6 billion annually to promote the use of its products in the United States. Although the industry claims that none of this effort is aimed at the youth market, research shows that, in fact, this is the market that they are reaching. The "Joe Camel" icon was as recognizable to children as Mickey Mouse in one survey. Internal industry documents detail the importance of capturing the youth market and enticing them to use their company's brand of cigarette. Fruit flavors, particularly appealing to the young, have been added to smokeless tobacco and to the imported Indian cigarettes known as "bidis." The tobacco industry has paid scientists to dispute evidence of nicotine addiction and the health hazards that tobacco use creates, and then failed to disclose their financial support of these scientists.

High-Risk Sub-Populations. The tobacco industry's marketing efforts have targeted youth, women and minority groups. As a result, their use of tobacco products in Maryland is now comparable to the general population as a whole. However, minorities are disproportionately impacted by tobacco-related disease. In 1996 for example, the incidence of lung and bronchus cancers among the African-American population was 22.5% higher than in the white population. Recent studies hint that the higher incidence of disease may be due to differences in how nicotine is metabolized, heightening the addictiveness of nicotine and thus leading to greater intensity of tobacco use. Among Maryland adults, the greatest disparity in tobacco use is between income groups.

The overarching goals for 2010 are to: 1) increase the quality and years of healthy life; and 2) eliminate health disparities. Reducing the overall use of tobacco products and eliminating disparate high use among high-risk populations will achieve these two goals. In the fall of 1998, Maryland joined in a Master Settlement Agreement to settle state lawsuits against the tobacco industry. Under the terms of that settlement, Maryland will receive an estimated $4.2 billion over the next 25 years, deposited to the Cigarette Restitution Fund (CRF). The CRF is a "special fund" from which the General Assembly may appropriate funding for programs dedicated to tobacco use prevention, cancer, or any other public purpose.

In the summer of 1999, Governor Glendening appointed the Task Force to End Smoking in Maryland and charged it with developing specific goals and programs for reducing tobacco use in Maryland, with the proceeds of the settlement being made available by him from the CRF to fund recommended activities. These objectives include:

Objective 1 - By 2010, reduce tobacco use among Maryland adults by 50% from the 2000 base rate.

Objective 2 - By 2010, reduce tobacco use among Maryland school-age youth by 50% from the 2000 base rate.

Objective 3 - By 2010, reduce the proportion of women who use tobacco products during pregnancy by 50% from the 2000 base rate.

Objective 4 - By 2010, increase the proportion of women who quit smoking because of pregnancy by 50% from the 2000 base rate.

Objective 5 - By 2010, have all health plans in Maryland include smoking cessation as a covered service.

Objective 6 - By 2010, have at least 90% of primary care providers provide smoking cessation advice and support to their patients who use tobacco products.

Objective 7 - By 2010, have tobacco retailers achieve a 99% compliance rate with Maryland's laws prohibiting the sale of tobacco products to minors.

Objective 8 - By 2010, decrease the number of children who are exposed to secondhand smoke by 75% from the 2000 base rate.

Objective 9 - By 2010, have locally developed tobacco use prevention and cessation coalitions operating in every Maryland county and the City of Baltimore.

Action Steps

In April 2000, the General Assembly codified significant portions of the Task Force Report, and delineated a phased implementation plan for an ambitious new Tobacco Use Prevention and Cessation Program in SubTitle 10 of the Maryland General Health Article (Senate Bill 896 and House Bill 1425). The "Action Steps" outlined below are driven by the mandate of that legislation.

- ⇨ Conduct baseline tobacco studies of youth and adult tobacco use in Maryland, using the Youth Tobacco Survey and the Adult Tobacco Survey as formulated by the Centers for Disease Control and Prevention.

- ⇨ Undertake formative research in support of a counter-marketing campaign.

- ⇨ Facilitate the development of tobacco use reduction and cessation plans in each county and in the City of Baltimore which address: smoking cessation, tobacco use by school-age youth, community-based tobacco control programs, enforcement of existing youth access laws, reducing exposure to secondhand smoke, and eliminating disparities in tobacco use among high-risk populations. Develop jurisdiction-specific tobacco control goals and objectives in support of the 2010 objectives herein.

- ⇨ Develop and issue Requests for Proposals in support of a counter-advertising campaign and a grant process for funding community-based tobacco use reduction and cessation activities.

- ⇨ Institute a data collection and evaluation process whereby program design can be informed and enhanced on an ongoing basis and progress towards achieving goals can be assessed.

- ⇨ Actively coordinate community-based tobacco control activities and provide technical assistance as requested to those involved in such activities.

- ⇨ Establish a formal advisory body to provide insight and concerns from high-risk population groups, the latest scientific information, input from local coalitions, and the perspectives of interested statewide organizations.

Partners

Maryland Department of Health and Mental Hygiene (DHMH) • Maryland Local Health Departments • Office of Health Promotion, Education, and Tobacco Use Prevention, DHMH • Supporters of the Task Force to End Smoking in Maryland

Related Reports

Alcohol and Drug Abuse Administration, Maryland Department of Health and Mental Hygiene. (1999). *Maryland Synar report.*

Centers for Disease Control and Prevention. (1999, August). *Best practices for comprehensive tobacco control programs*. Report. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Maryland Department of Health and Mental Hygiene, Task Force to End Smoking in Maryland. (1999, December). *Making Maryland the tobacco-free state*.

U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention. (1998). *1988 Surgeon General Report: The Health Consequences of Smoking: Nicotine Addiction.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.

Cross-Reference Table for Tobacco

See Also

Dorchester County 194
Somerset County 265